ATTACHMENT IV
FINANCING

1.0 Financing Principles

1.1 Operating Practices

The Contractor shall adhere to Generally Accepted Accounting Principles and all federal and state regulations. The following documents shall guide program accounting procedures:

(1) OMB Circular A-87
(2) OMB Circular A-133
(3) G. S. 159
(4) Audits of State and Local Governmental Units, issued by the American Institute of Certified Public Accountants (current edition).

1.2 General Financial Planning

The DHHS shall pay to the Contractor Medicaid funds, State funds, and State-allocated federal funds, as agreed to in this contract. The DHHS shall immediately notify the Contractor of modifications in funding commitments in this contract under the following conditions:

(1) Action by the North Carolina Legislature that removes any funding for, or authority to provide for, specified services.
(2) Action by the Governor pursuant to executive order that removes the funding for specified services or that reduces the DHHS funding level below that required to maintain services on a statewide basis.
(3) A formal directive by the Governor, or the State Budget Office on behalf of the Governor, requiring a reduction in expenditures.
(4) Action by the United States Congress or a federal agency that decreases the federal funding available to be allocated to the Contractor by DHHS.

In the event that any of the conditions specified in the above items occur, the DHHS shall issue an amendment to this contract reflective of the above condition.

2.0 Reviews and Audits

2.1 Overview

The DHHS will conduct reviews and audits of the Contractor regarding performance under this contract. The DHHS shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the Contractor.

These reviews and audits will focus on Contractor compliance with State and federal laws, rules, regulations, policies, and waiver provisions, in addition to contract provisions and Contractor policy and procedure.

Reviews and audits shall be conducted according to the following protocols, except when conditions appear to be severe and warrant deviation. Note that, in addition to the Contractor, all providers enrolled in the Contractor's QPN who receive Medicaid funding directly from the Division of Medicaid Assistance or through the Contractor are subject to Medicaid audit and program integrity functions and activities.

2.2 Reviews

The DHHS will schedule reviews at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance notice is prohibited by rule or federal regulation, or when the DHHS determines that conditions warrant an unannounced or short notice review.

Except as precluded, the guideline, protocol and/or instrument to be used to review the Contractor or a detailed agenda if no protocol exists, shall be provided to the Contractor at least 30 days prior to the review.

At the conclusion of the reviews, the DHHS shall conduct an exit interview with the Contractor. The purpose of the exit interview is to allow the DHHS to present the preliminary findings and recommendations.

Following the exit review, the DHHS shall generate a report, within 45 days, identifying the findings and recommendations that require a response by the Contractor.

The Contractor shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The Contractor may also present new information to the DHHS that demonstrates compliance with questioned provisions at the time of the review. When access or care to individuals is a serious issue, the Contractor may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified above.

The DHHS will review the POC, seek clarifying or additional information from the Contractor as needed, and issue an approval of the POC within 30 days of having required information from the CONTRACTOR. The DHHS will take steps to monitor the Contractor implementation of the POC as part of performance monitoring.

The DHHS shall protect the confidentiality of the records, data and knowledge collected for or by individuals or committees assigned a peer review function in

planning the process of review and in preparing the review or audit report for public release

The Contractor may appeal findings reflected in review reports through the dispute resolution process identified in this contract.

2.3 Audits

The DHHS will schedule audits at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance notice is prohibited by rule or federal regulation. An entrance meeting will be conducted to review the nature and scope of the audit. At the conclusion of the on-site audit process, the DHHS shall conduct an exit interview with the Contractor. The purpose of the exit interview is to allow the DHHS to present the preliminary findings and recommendations. Following the exit review, the DHHS shall generate a preliminary report, within 45 days, identifying the findings and recommendations that require a response by the Contractor. The Contractor will have 30 days to initiate an appeal process.

3.0 Reporting and Settlement

3.1 Reporting

The Contractor shall report financial data to DHHS in a manner prescribed by the Secretary. Such reporting shall minimally include the following:

Quarterly	Financial Monitoring Report
Four Quarterlies and Final Report	Claims Aging Report - MH/SA/DD, separate
Four Quarterlies and Final Report	Financial trial balance - MH/SA/DD, separate
In accordance with G.S. 159, submitted through the Local Government Commission	Annual Audit Report, Management Letter, and Contractor Response to the Management Letter
By October 15, 2003, quarterly thereafter if changes occur.	Staffing matrix indicating personnel by classification and credentials. Data will include salary information. Required for cost allocation purposes.

3.2 Settlement

The per citizen per month LME payment will be subject to a separate year-end settlement process to ensure that Medicaid funds have not been paid in excess of actual cost. Medicaid regulations at 42CFR_____ limit federal financial participation to actual cost in public agencies. If the year-end settlement determines that federal Medicaid funds have been paid in excess of Medicaid-allowable cost, the excess federal funds must be repaid. Any State funds paid in

excess of actual cost will not be subject to repayment, except in accordance with DMH/DD/SAS fund balance requirements.
Medicaid payments for services shall be paid on a fee-for-service basis through claims filed by the Contractor. No year-end settlement shall occur on those funds, though the Contractor is liable to refund any claims determined to have been paid inappropriately as a result of an audit of the Contractor or its QPN.

DMH/DD/SAS service funds are paid in two categories. Funds designated as "Unit Cost Reimbursement (UCR)" shall be paid on a fee-for-service basis through the Integrated Payment Reporting System. Such funds are deemed to have been settled at the time of payment, subject to subsequent audit. Funds designated as "Non-Unit Cost Reimbursement (Non-UCR)" shall be paid and settled in accordance with procedures established by the Office of the DHHS Controller.

3.3 Fund Balance

The Contractor shall maintain a fund balance in accordance with the regulations of the Department of the State Treasurer Local Government Commission. If the fund balance exceeds fifteen percent (15%) of the Contractor's total budget, the funds in excess of fifteen percent (15%) are subject to repayment to the Department in accordance with 10A NCAC 27A.0111

4.0 Coordination of Benefits and Third Party Liability:

4.1 Payer of Last Resort

The DHHS is and shall be a payer of last resort in the event any one or more other third party payers are responsible for covered services provided to enrolled and eligible persons.

4.2 Coordination of Benefits

The Contractor shall coordinate benefits so that costs for services otherwise payable by the DHHS are cost avoided or recovered from a liable first or third party payer. The Contractor's claims system shall include appropriate edits for coordination of benefits and third party liability.

4.3 Dual Medicare/Medicaid Eligibility

Some consumers are eligible for both Medicare and covered services. These enrolled persons are referred to as dual eligible. There are different costs sharing responsibilities that apply to dually eligible persons based on a variety of factors. The Contractor is responsible for adhering to the cost sharing responsibilities presented in DHHS policy. The Contractor has no cost-sharing

obligation if the Medicare payment exceeds what the Contractor would have paid for the same service of a non-Medicare eligible person.

4.4 Retention of Collections

The Contractor may retain any third party revenue obtained for enrolled persons if all of the following conditions exist:

(1) Total collections received do not exceed the total amount of the Contractor financial liability for all enrolled persons.
(2) There are no payments made by DHHS related to fee-for-service, reinsurance or administrative costs (i.e. lien filing, etc.)
(3) State or federal law does not prohibit such recovery.

4.5 Payer Information

The Contractor agrees to obtain or cause to be obtained, all relevant payer information from each enrolled person and his or her guardian and/or family in connection with the establishment of that person's eligibility for covered services. The Contractor shall make such information available to each subcontracted provider involved with that person.

4.6 Co-payment

In the event that the Contractor assesses a co-payment in accordance with State or federal requirements, the Contractor shall be allowed to retain the co-payment collected, as long as the total collected from all parties does not exceed the cost of services to all consumers.

4.7 Primary Payer

Each Contractor shall bill claims for covered services to any primary payer when information regarding such primary payer is available, or at the request of DHHS.

4.8 Cost Avoidance and Recovery

DHHS is the payer of last resort. This means that State and State-allocated funding shall be used as a source of payment for services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery.

The Contractor shall cost avoid all claims or services that are subject to third-party payment and may deny a service to an enrolled person if it knows that a third party (i.e. other insurer) should provide the service. However, if a third-party insurer (other than Medicare) requires the enrolled person to pay any co-

payment, coinsurance or deductible, the Contractor is responsible for ensuring that such payments are collected. The Contractor liability for coinsurance and deductibles is limited to what the Contractor would have paid for the entire service pursuant to a written subcontract with the provider or the DHHS service rate, less any amount paid by the third party.

If the Contractor knows that the third party insurer shall neither pay for nor provide the service, and the service is medically necessary, the Contractor shall not deny the service nor require a written denial letter. If the Contractor does not know whether the third party covers a particular service, and the service is medically necessary, the Contractor shall contact the third party and determine whether or not such service is covered rather than requiring the enrolled person to do so.

The requirement to cost avoid applies to all covered services. In emergencies, the Contractor shall provide the necessary services and then coordinate payment with the third-party payers. The Contractor shall also provide medically necessary transportation so that enrolled persons can receive third-party benefits. Further, if a service is medically necessary, the Contractor shall ensure that its cost avoidance efforts do not prevent an enrolled person from receiving such service and that the enrolled person shall not be required to pay any coinsurance or deductibles for use of the other insurer's providers.
Post-payment Recovery is necessary in cases where the Contractor was not aware of third-party coverage at the time services were rendered or paid for, or was unable to cost avoid. The Contractor shall identify all potentially liable third parties and pursue reimbursement from them except in the circumstances below unless the case has been referred to the Contractor by DHHS:

(1) Uninsured/underinsured motorist insurance
(2) First and third-party liability insurance
(3) Tortfeasors, including casualty
(4) Special Treatment Trusts
(5) Worker's Compensation
(6) Estates
(7) Restitution Recovery

The Contractor shall report any cases involving the above circumstances to DHHS should the Contractor identify such a situation. The Contractor shall cooperate with DHHS in all collection efforts.

5.0 First Party Payments

5.1 Sliding Fee Schedule

For non-Medicaid covered services, the Contractor shall determine the fee to be charged to the eligible or enrolled person according to the sliding fee schedule

approved by the Contractor's Board. The Contract shall ensure that all providers in its QPN apply the Board-approved sliding fee schedule in a uniform manner.

5.2 Retention of Fees

Any required co-payments collected shall belong to the Contractor or its subcontracted providers, as defined in the provider's subcontract with the Contractor as an offset against the cost of service.

6.0 Funding

6.1 Systems Management

The Contractor shall be paid a monthly Systems Management rate based on the modeled costs of the system management functions detailed in the Scope of Work attached to this contract. The rate is based upon the cost that should be predicted for an efficient Systems Manager. Excess systems management funds shall be used to expand services for non-Medicaid consumers in the catchment area, subject to the settlement provisions in 3.3, above.

The systems management rate is based upon a per citizen per month (PCPM) computation using the projected population of the Contractor's catchment area as of July 1, 2004, as projected by the State Demographics Unit of the Office of State Budget and Management. The payment for the fiscal year is as follows:

_____population X $__.__ (rate) X 12 months = _____ Annual Maximum

The Systems Management rate will be funded entirely from State and Medicaid funds. If a county chooses to provide additional funding for Systems Management functions, such additional funding must be in addition to the required county contribution for services per G. S. 122C-115.

6.2 Funds for Services Allocated by the DMH/DD/SAS

The Department shall provide the Contractor with an annual allocation of State and State-allocated federal funds for mental health, developmental disabilities and substance abuse services to non-Medicaid eligible consumers and for non-Medicaid covered costs and services. Allocations shall be designated as Unit Cost Reimbursement (UCR) or non-UCR. UCR allocations shall be earned through IPRS. Non-UCR expenditures will be reimbursed by the DHHS Controller's Office following submission of a statement in the format dictated by the Controller's Office that documents that funds have been expended for the purpose for which they were allocated. The initial Continuation Allocation of funds is included in the last page of this Attachment. Allocation letters issued subsequent to the signing date of this Contract shall constitute amendments to the Contract.

6.3. Medicaid Fee-for-Service Reimbursement

The DHHS shall reimburse the Contractor in accordance with Medicaid reimbursement policies for billings submitted by the Contractor for Medicaid eligible consumers receiving Medicaid covered services. An estimate of the revenue to be received, based upon actual billings in SFY 2003, is included on the last page of this Attachment.